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BMJ paper Social prescribing

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Clinical Update

Social Prescribing

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Box start

What you need to know

- Emerging evidence suggests that social prescribing can improve people's health and wellbeing and reduce workload for healthcare professionals and demand for secondary care services
- In England social prescribing is part of the NHS Long Term Plan. Primary Care Networks will be funded to employ a social prescriber from 2019
- Social prescribing is targeted at a range of patients, including those who are socially isolated and those with physical long term physical and/or mental health conditions

[Two further points needed. We suggest:

- A social prescribing link worker (also called health trainers or community navigators) is a facilitator who provides support for service users, including helping service users identify

goals, enabling access to sources of community support and providing motivational support.

• Further research is needed to…]

Box end

Non-medical interventions are increasingly being proposed to help patients improve health behaviours and better manage their conditions [Re-phrased slightly, OK? Yes]. This is known as social prescribing. In England, the NHS Long Term Plan states that nearly one million people will qualify for referral to social prescribing schemes by 2023/24.[3] Primary care networks, announced as part of the 2019 GP contract, will be funded to employ one social prescriber each from 2019.[4] [I think this has been superseded by the new GP contract – so changed this]. The social prescribing approach is also attracting interest in North America,[5 6] Australia,[7] and Scandinavia.[8] This clinical update will outline what social prescribing is, the evidence behind it, and offer some tips for embedding social prescribing within healthcare systems.

What is social prescribing?

Socioeconomic factors have consistently been found to have a greater impact on health than healthcare. In addition, frailty and long term conditions can have a devastating effect on social and physical activity, finances, and relationships, which in turn can lead to a further decline in health and wellbeing [Suggest adding this, or similar, to set the scene further. Ie what is the theory behind social prescribing/hypothesis?

Also will need references eg (I got these via king's fund, but I'm sure you will have a broader knowledge of the evidence here):

McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. Health Affairs 21 (2) pp.78-93.

Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. (2012) Healthy places: Councils leading on public health. London: New Local Government Network. Available from New Local Government Network website

Bunker, J.P., Frazier, H.S. and Mosteller, F. (1995) The role of medical care in determining health: Creating an inventory of benefits. In, Society and Health ed Amick III et al. New York: Oxford University Press. Pp 305-341.]

Social prescribing attempts to improve health by addressing some of these socioeconomic factors. It does this by linking traditional clinical practice with activities and support services

within the community (fig 1). A "social prescription" is a referral to one or more of these activities, which are typically provided by the local voluntary and community sectors. Referral mechanism, target groups, activities offered, and the intensity and duration of support provided vary.

Fig 1 Caption

Is there evidence that social prescribing works?

While evidence is emerging in support of the benefits of social prescribing, to date this evidence is insufficient to provide definitive guidance on what works.[19] [Could you say a bit more about this ref?] Evaluating social prescribing schemes can be challenging due to the complex and wide ranging issues it seeks to address, wide variations in the nature of interventions, the wide range of additional influences on individual health and wellbeing [by which you mean confounding factors?], the time taken for benefits to emerge, and the expense of thorough evaluation.[20] Many current evaluations are small scale, short term, poorly designed, lack standardised outcome measures, and fail to account for wider influences on health and wellbeing.[19]

However, the lack of robust evidence of effectiveness does not mean social prescribing is ineffective. Findings from qualitative studies suggest that patients are satisfied with social prescribing schemes, particularly valuing a trusting and supportive relationship with their link worker, the time and space to address social problems, and link workers' extensive knowledge of the range of community support services available.[21-24] Recent systematic reviews of non-clinical community interventions [of RCTs? What type of info?] identified evidence, albeit weak, of a further range of patient benefits.[19 25] These include improvements in mental wellbeing and in physical health and health behaviours; reductions in social isolation and loneliness; and reductions in primary and secondary care usage. Stronger evidence [what sort of evidence?] from the United States supports the effectiveness of interventions aimed at identifying and addressing families' resource needs and programmes providing linkage to employment support for certain vulnerable groups.[26]

How could the evidence be improved?

To aid evaluation, social prescribing programmes need to be underpinned by a clear understanding of the intended impacts, the mechanisms by which impacts are achieved, and how each programme fits into wider health and social care systems and the communities in which it operates.[20] The Choice and Personalisation Team at NHS England has recently

produced a draft common outcomes framework for discussion.[27] This proposes a common approach to measuring outcomes for the person (for example, being better able to manage their own care [OK?]), for the health and care system (a change in the number of GP consultations), and for local community groups (capacity to manage referrals). Measuring these is not without problems [are there any big ones that you can briefly describe?] and will require further work if a robust evidence base is to be developed. [Deleted the NIHR ongoing research. If you want, you could create a new box that includes a list of ongoing RCTs/research from a search of trials database]

What are the risks and harms of social prescribing?

There is a risk that social prescribing is treated as a panacea for complex problems and social issues such as loneliness, poverty, and increasing inequalities. While social prescribing is likely to be of benefit to many patients, for others it will not be appropriate [for whom would it not be appropriate?]. Social prescribing also risks being viewed as a "silver bullet" to fix growing demand pressures facing health services. The primary driver needs to be benefit to patients.[29] In addition, if the link worker model, described below, is to be rolled out, some critical issues need to be addressed. For example, what are the role's core competencies, and should there be an accredited qualification?[30] Should the role always be paid, or could it be performed by volunteers or by a mix of both? Should link workers be managed within the health or the voluntary sector? Finally, it is important to recognise wider social policy contexts within which social prescribing is delivered, specifically the constraints on the UK's voluntary and community sectors imposed by a prolonged period of austerity and the impact of reductions in local authority budgets between 2010 and 2018.[31] This, coupled with growing demand for services, may make it more difficult to refer patients into community activities [Do you mean due to a lack of capacity? ie, not enough community activities to refer people into?]. Against this backdrop, balancing funding for link workers [Changed from facilitator – need to use consistent terms throughout] and activities requires planning by commissioners, service designers, and the voluntary and community sector. Giving link workers a brief to generate local activities and a limited budget to spot purchase some activities is an option, but local circumstances will dictate the best model.

Social prescribing in practice

Who are the target groups for social prescribing?

A key target group is patients who require a greater level of support [By support you mean what? Presumably not clinical support ie decision making. Do you mean need more time to understand health messages? Are unable to make a start/maintain lifestyle changes alone? This may be due to…Eg frailty, multiple comorbidity, learning disability, ?? – would it also extend to drug and alcohol problems, literacy, chaotic lifestyles, - how do you define the boundaries of this?] than is available in routine care. The social prescribing scheme that we have developed, "Ways to Wellness," targets people with a range of long term physical and mental health conditions living in an area of high socioeconomic deprivation.[11] Other schemes target people with mental health conditions,[14] or frail older people.[15]

[Please add a sentence or two to explain how and when people can be identified (eg part of any annual review, any appointment, or only in your more complex patients? – it's not really coming across yet where this fits in to daily practice. Figure 1 implies only at annual review. Should the clinician be doing initial goal setting an refer on, or should they defer that to a link worker or someone else? – what are the different (common) models for referral? Refer to figure 2 in this section.] Different people will require different levels of support to engage with activities (fig 1). At one end of the scale, someone with a high level of health literacy and motivation will find out and do all that needs to be done without any support. At the other end of scale, someone who is feeling overwhelmed or depressed may need intensive [OK?] personal motivational support. In between, others may need signposting and information about the range of support and activities available.

What sort of activities do people get involved in?

Our initiative in Newcastle, northeast England, offers more than 130 different activities, many [most?] of which are no-cost or low cost. Activities and services can be roughly grouped into: physical activities (such as "green gyms" and exercise classes); weight management and nutrition; arts based activities [to address what sort of issues?]; employment based and volunteering activities; and support to access welfare rights, debt, and housing advice and advocacy services. Some social prescribing interventions provide free, time limited activities (for example, providing six weeks' free exercise classes).[18]

Who provides social prescribing services?

Social prescribing services can be provided by the voluntary sector,[11 12] primary care practices acting as hubs for local community wellbeing,[13] or by partnerships between health service commissioners and the voluntary sector.[14]

Who can make a social prescribing referral?

Patients can self refer to social prescribing schemes, or be referred by a clinician or other member of the healthcare team [Added to stress that in many places receptionists or other staff are trained in signposting to these services. ok?]. The referral may be directly to an activity, such as physical exercise, or to a link worker or facilitator. Digital social prescribing is also being developed, for instance using an app that matches patients with non-medical activities that may benefit their health condition [So this is self referral via an app?].[16] In the United Kingdom, referrals from generalist clinicians working in the community are most common, but referral can also be from specialist services, for instance for people recovering from cancer[9] or those with dementia.[10]

What is a link worker?

Facilitators who provide support within social prescribing are known by a variety of titles, including community navigator, health trainer, social prescribing coordinator, and community connector [Are these all UK terms?]. However, "link worker" is an increasingly popular title because it references the need for a link between referring clinicians, patient, and local voluntary and community sectors. Figure 2 shows the stages in referral to a link worker. In the United Kingdom, this approach is gaining traction, particularly in disadvantaged communities where problems are more complex and challenging and more intensive support is likely to be required.[17]

Fig 2 Caption

Key aspects of the link worker role include: working with patients to identify meaningful goals; co-producing an action plan with the patient; enabling access to activities and sources of support in the community, and providing ongoing motivational support to help patients achieve their goals. In some schemes, link workers also work with referrers to generate referrals [Please clarify – referrals to the link worker, or referrals for medical care?] and provide feedback to referring clinicians on patients' progress. Ideally a link worker is someone with community connections and an in-depth knowledge of sources of community activities and support. An understanding of the local community is particularly crucial in areas of socioeconomic disadvantage, as the link worker role may also involve generating and building capacity in the local voluntary and community sectors to provide a wide range of local activities. The recent NHS Long Term Plan for England includes the aim to recruit more than 1000 trained social prescribing link workers by the end of 2020/21, with a further increase by 2023/24.[3]

Box start

Box 1 Why social prescribing is gaining support

Increasing evidence shows that social factors such as education, income, and housing influence health behaviours and have a major impact on health. [Please cite evidence for this Eg king's fund or the three references below: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

• McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. Health Affairs 21 (2) pp.78-93.

• Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. (2012) Healthy places: Councils leading on public health. London: New Local Government Network. Available from New Local Government Network website

Bunker, J.P., Frazier, H.S. and Mosteller, F. (1995) The role of medical care in determining health: Creating an inventory of benefits. In, Society and Health ed Amick III et al. New York: Oxford University Press. Pp 305-341.]

• We need rethink the balance between the biomedical and the social and psychological model of care in clinical practice [because? Evidence?]

• Interest is growing in a more personalised approach to healthcare delivery, with more effective partnerships between patients and professionals [Add ref]

• Social prescribing is presented as an effective way of addressing social determinants of health whilst [potentially?] reducing healthcare demand and costs.[Add ref]

Box end

Box start

Box 2: Embedding social prescribing into your way of working.

These tips are drawn from our experience in developing Ways to Wellness, a link worker social prescribing scheme in Newcastle, England.

- Build links with your local voluntary and community sector. A good starting point is the National Association for Voluntary and Community Action,[32] which offers useful information and seeks links with general practices
- Discuss social prescribing with your patient participation group. They may have ideas about how to take it forward and champion it in the practice
- Decide which patient group/s to target. Focusing on a particular area may be helpful; for example, patients with long term conditions such as type 2 diabetes, socially-isolated patients, or those with anxiety and depression
- Consider adding a social prescribing option to annual care plans, health checks, or frailty reviews as part of care and support planning[33]
- Talk to other local practices and identify a local lead who can support people into activities**. From April 2019 the GP contract includes funding for a social prescriber within each primary care network.**[5] [Added, and ref 5 – OK?]
- The whole practice team needs to plan how to encourage patients to take up the offer of a social prescription
- Provide patients with a full explanation of the social prescribing programme offered. This has been found to help manage patient expectations of the service and increase their satisfaction[19]
- In partnership with link workers or the organisation dealing with referrals, clarify and agree referral criteria and feedback mechanisms. Develop a referral form that collects basic patient data and patient consent to share information. Consider how the practice

will collect feedback from referred patients [Can you suggest some outcome measures for audit/evaluation? How do you know if it's working, or not working? How do you know if it's cost effective? And/or add reference so people can read more. See also comment on next point]

- Referral and audit will be easier if [Would you say this is an important part of the plan, and needs to considered from the outset? Can you suggest a quality improvement tool/framework that practices can use?] you systemise social prescribing as part of your IT system.

Box end

Box start

Education into practice:

Think about which of your patients might benefit from seeing a link worker who could link them into local community and voluntary sector services.

• What social issues do you often feel unable to help patients with that might be addressed with the help of a link worker?

• [Suggestion] How would you evaluate whether your social prescribing scheme is accessible, helping patients, and cost effective?

Box end

Box start

Search strategy

Information in this article came from a personal archive of references.

[Can you develop this further?

Outline in 150 words the sources of information used to prepare the update and how you selected what to include. Please say whether you have done a Medline search and if so broadly the terms, used a personal archive of references, or consulted other experts. We do not expect you to perform a systematic review yourself, but we do hope you will consult databases such as Clinical Evidence and the Cochrane Collaboration. Where you have used databases, please include the search terms used.]

Box end

Box start

How patients were involved in the creation of this article:

Patients [How many?] from Ways to Wellness have read this article. Although patients have been heavily involved in the development of and continuing review of Ways to Wellness,[34] none of those who read the article felt able to comment on the wider aspects of social prescribing discussed in this article.

Box end

Box start

Useful information resources

• The Social Prescribing Network. https://www.socialprescribingnetwork.com

• The King's Fund. What is Social prescribing. https://www.kingsfund.org.uk/publications/social-prescribing

• NHS England. https://www.england.nhs.uk/personalised-health-and-care/social-prescribing

• Skills for Care. https://www.skillsforcare.org.uk/Careers-in-care/Job-roles/Roles/Social-prescriber.aspx

• Local Government Association. https://www.local.gov.uk/just-what-doctor-ordered-social-prescribing-guide-local-authorities-case-studies

- Healthy London Partnership. https://www.healthylondon.org/wp-content/uploads/2017/10/Social-prescribing-Steps-towards-implementing-self-care-January-2017.pdf
- National Association for Voluntary and Community Action. https://navca.org.uk/
- Ways to Wellness. https://waystowellness.org.uk.

Box end

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Further details of The BMJ policy on financial interests is here: https://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests

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